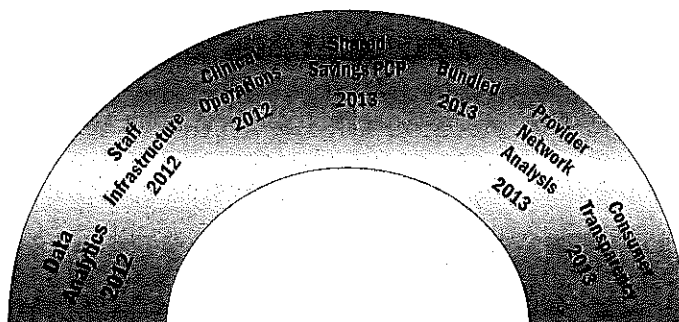
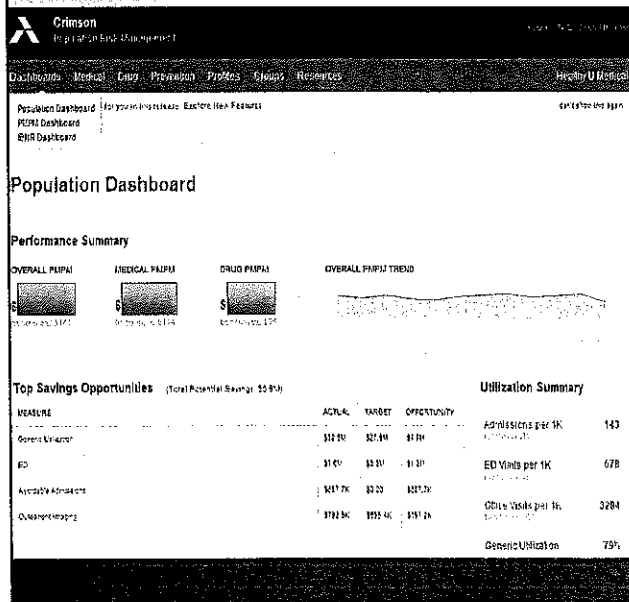


MCAC Healthy U ACO Update



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HEALTH PLANS

Grimson Population Risk Management Data Analytics



- 5 years of Healthy U Claims History
- Comprehensive cost and quality assessments on population health
- Care gap analyses based on evidence-based guidelines
- Alliance with Milliman Medinsight for risk-adjusted population benchmarks



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HEALTH PLANS

Prevention

Chronic Disease Management High Priority Members Evidence-Based Measures

Chronic Condition						
Chronic Condition Overview						
<ul style="list-style-type: none"> Active cancer Asthma Both CAD & diabetes CAD without diabetes Chronic musculoskeletal/osteo arthritis/osteoporosis COPD Dermatologic disorders Diabetes without CAD Gastrointestinal disorders Hemophila & sickle cell & chronic blood disorders HIV Hypertension (includes stroke & peripheral vascular disease) Liver disease (Hepatitis, Cirrhosis) - post transplant Major psychosis Mental retardation/disability congenital anomaly Neurologic disorders Other chronic conditions Other mental health/substance abuse Renal failure - post transplant Severe dementia Severe heart failure/transplant/rheumatic heart disease/non-rheumatic valvular heart disease Severe rheumatic & other connective tissue disease Thyroid disorders Unhealthy newborns and preemies 		TOTAL	NORM	DIFFERENCE	MEMBERS PER	MEMBERS PER
		PI	PMPM		1K	1K BENCHMARK
		7070	\$289.95	\$560.75	29.01	13.65
		3426	\$390.25	\$263.92	32.75	27.39
		49	\$645.61	\$750.93	11.95	6.19
		7154	\$350.35	- \$56.82	44.55	55.07
					6.25	8.88
					6.68	1.33
					10.71	5.7
					12.41	10.12
					18.38	21.73
					13.17	8

Prevention

Chronic Disease Management High Priority Members Evidence-Based Measures

The Time Period Focus setting does not affect data on this page.

410 MEMBERS

1% of population

Medical PMPM

\$2.4K

population avg: \$159.80

Drug PMPM

\$1.3K

population avg: \$99.73

ED Visits per 1k

2987

population avg: 630

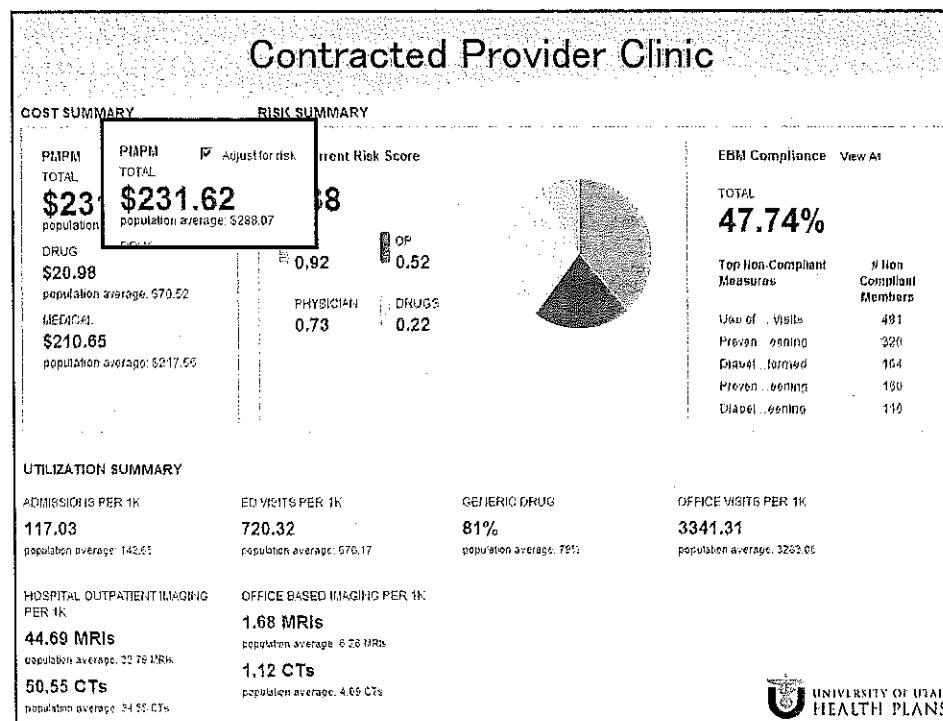
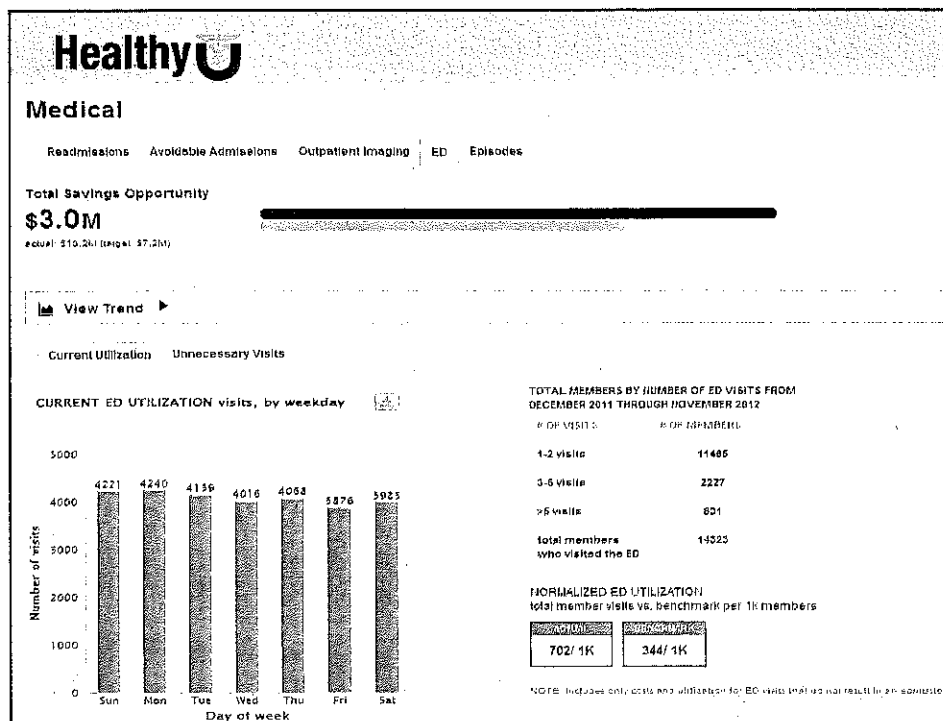
Admissions per 1k

575

population avg: 69

High Priority Members

MEMBER	AGE	PROSPECTIVE RISK SCORE	PRIMARY CARE PHYSICIAN	TOTAL COST	CHG
	55	69.79	FLYNN, MICHAEL C	\$229.6K	Renal failure - post transplant
	59	42.15	LEWIS, RAN... J	\$160.5K	Major psychosis
	44	33.91	NUTTALL, AVIS, T	\$117.9K	Active cancer
	16	33.45	LAM, TOAH H	\$243.2K	COPD
	32	33.41	FARRUGH, ... H, M	\$58.8K	Asthma
	31	32.21	CLEMENS, PET... C	\$92.8K	Severe heart failure/rheumatic heart disease
	60	31.51	RAGLE, ... JOHN, J	\$64.5K	Renal failure - post transplant
	46	30.41	CAIRN, THOMAS, H	\$49.3K	Liver disease (Hepatitis, Cirrhosis) - post transplant
	11	20.40	MATTHEWS, ... H	\$122.8K	Diabetes without CAD



Staff Infrastructure

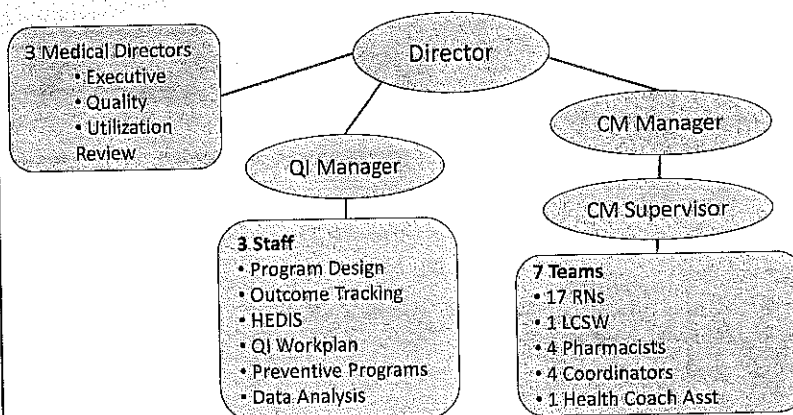


2012 at 50

Today at 100



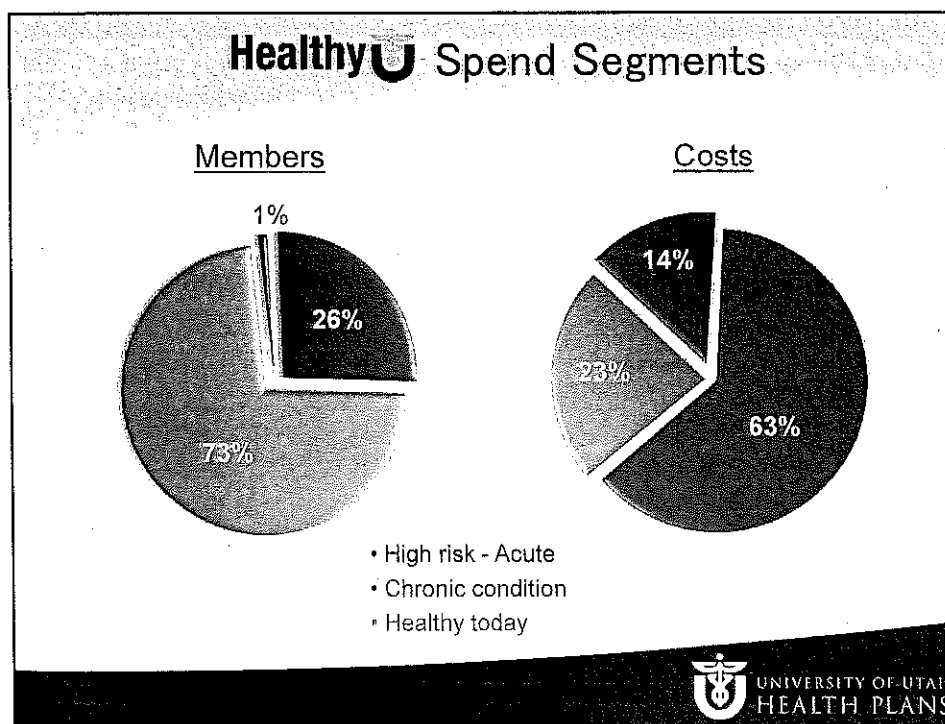
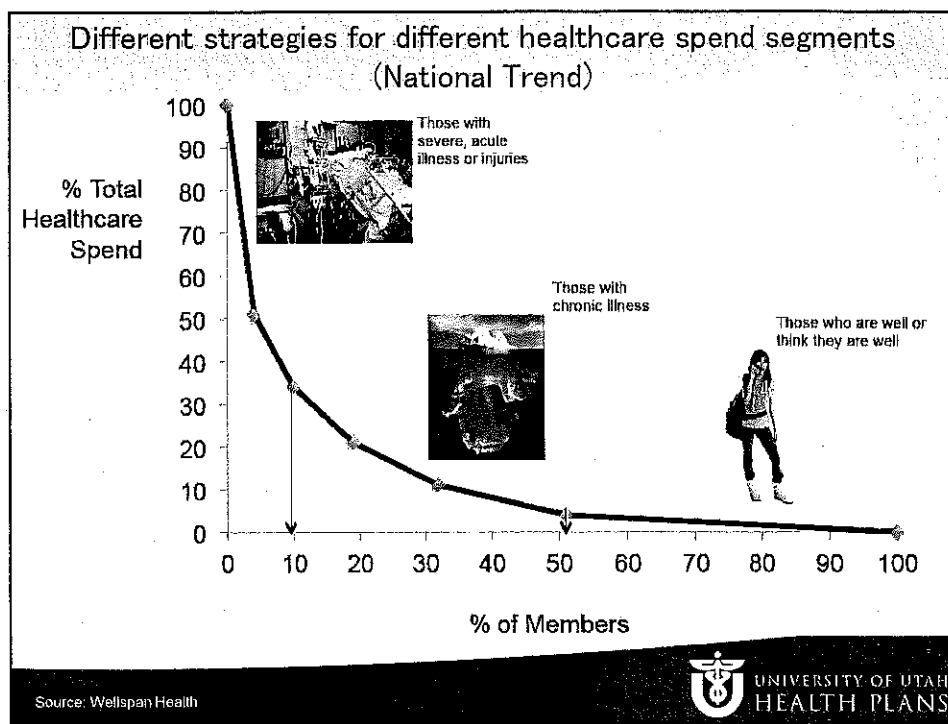
Clinical Operations Team



Responsibilities:

Utilization review, prior authorization, medical claim review, disease management, outcome monitoring, care management plans, patient engagement, collaboration with other key players.





Medicaid Advisory Committee – ACO Update

Clinical Operations

Care Management Programs:

- U Baby Program = Program serving all pregnant moms, high risk and low risk
 - Maternal, Newborn health risk assessment
 - High risk targeted case management
 - College of Health - OT Student conducting home visits for bedrest, high risk preterm moms
 - Outcome tracking
 - U baby committee monthly meetings with physician champions



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HEALTH PLANS

- Emergency Room(ED)/Restricted Care Management Team
 - Targeted care management on the frequent flier patients using the ED
 - Focused care management with the Healthy U restricted members
 - Working with providers (PCPs) and pharmacist to coordinate care
 - Care plan design with patient, provider, pharmacy and care manager
 - Introducing mobile health paramedic visits with the Salt Lake City Fire Department on frequent ED members
 - Outcome tracking – ED utilization
 - ED Committee monthly meetings with physician champions, mental health, SLC Fire Department and hospital care managers and leadership.
- Special Needs population care management team
 - Pediatric care management conducting home visits to introduce our services
 - Partnership with Green & Healthy Homes to help children with asthma
 - Home assessments and renovation as indicated
 - Asthma for children – monthly reporting to Dept of Health



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HEALTH PLANS

- Adult care management conducting home visits to introduce our services
 - College of Health – Low back pain assisting in establishing best practice
 - Durable Medical Equipment protocol and revamping of policies & procedures
- Outcome tracking – Crimson analytics – individual per member per month costs and individual risk scoring
- Inpatient Navigator – University Hospital
 - Care management of all Healthy U members and University of Utah Hospital and Clinic employees admitted to the hospital
 - Introduction and tracking of the hospital stay
 - Assist with discharge planning
 - Follow up discharge calls – questionnaire
 - Validation of completed follow up appointment with provider
 - Outcome tracking – readmission rate, compliance to follow up appointment with provider
- Pharmacy Team – working with our care managers on the specialty pharmacy needs and polypharmacy utilization.
 - Participant on the Clinical Advisory Committee
 - Monthly utilization reports shared with care management teams.



- Wellness Coach – care manage members that are potential risk for chronic conditions
 - Asthma
 - Diabetes
 - Chf
 - Members that score high in frequent ED visits or multiple hospitalizations in a year will be care managed encouraging, PCP alignment, patient engagement and goal setting.
 - Encourage member sign up for “My Chart” – patient portal
 - Outcome tracking – Individual per member per month costs and risk scores

Other initiatives supporting care management:

- **GATE Utah** – Psychiatric consult web-based program supporting the primary care provider with patients that have mental health issues. This program can assist the PCP on treating mental health issues for their patient, whether needing clarity to a question and/or medication management issues.
- **LCSW consult services** – A social worker meets with the care managers caring for the Restricted/ED high utilizers to identify various therapeutic approaches to help engage the members.
- **Clinical Advisory Council** – This council meets every other month to address complex patient needs related to medical, mental health and pharmacy issues. This committee has representatives from hospital, administration, primary care, pharmacy, case management and health plan. The intent of this committee is to establish best practice or process that can be implemented to result in better care, lower cost and meet the patient expectations.



Initiatives in progress:

- ECHO Project – Providing consult services by specialist treating patients with Hepatitis C diagnosis.
- Diabetes management- Identify best practice on working with Diabetic Type II and metabolic syndrome patients.
- Asthma management of the pediatric and adults in compliance to medication management
- Palliative care – identify targeted population (Liver disease) where training is done for the care managers to meet the member in their home to discuss patient choice, quality of life and end of life decisions.

Quality Improvement Initiatives:

- HEDIS tracking and reporting
- CAHPS survey
- Preventive programs
 - Mammogram birthday card reminders
 - Flu shot campaign
 - Health plan website – preventive calendar – in development
- Outcome tracking of the care management programs
- Quality Workplan



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HEALTH PLANS

HealthyU

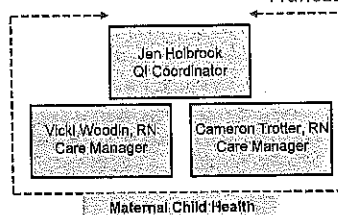
Managing Populations

**Physician Champions**

- Matthew Peterson, Chair OB/Gyn
- Erin Clark, M.D.
- Sean Esplin, M.D.
- Michael Varner, M.D.

Health Plan Quality Support:

- Linda Johnson, Manager
- Travis Ault, Project Administrator
- Frances Serrano


**Hospital Administrative Support**

- Erika Lindley, Service Director
- Gordon Crabtree



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HEALTH PLANS

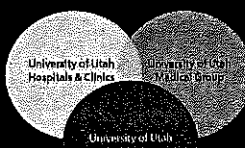
Value Based Payment Model: Primary Care



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Leading Utah in Value Based
Primary Care Payment

uhealthplan.utah.edu



- Improving Quality of Care
- Improving Patient Experience
- Reducing Per Capita Claims Cost

I. Value Based Payments	II. Embedded Care Management	III. SAQ Improvement	IV. Oversight & Monitoring	V. Data Sharing
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I. Value Based Payments

- Standard Fee For Service Payments
- Enhanced Fee For Service Payments
- Population Management / Thin Cap
- Shared Savings Payment
- 1st for the University of Utah

Implemented with Community Clinics
July 1, 2013



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HEALTH PLANS

I. Value Based Payments

Payment Methodologies

- In Development:
 - Bundled Payments: Obstetrics, Orthopaedic Surgery, Pediatrics
 - Capitation: DME/Home Health, Language Interpretation
 - Care Pathways: Headache, Back pain



Network Analysis

1. Quality/Cost/Access
2. University Strategic Alliances
 1. Referral Patterns
3. Provider Readiness Assessment for payment reform
 1. Patient Centered Medical Home
 2. ACO Capability

